Catholic Medical Center Obesity Treatment Center/Surgical Care Group
Preoperative Surgical Evaluation

Patient Name:_____ PCM:_____
DOB:_____ _____
CMC MR #:_____ _____

Date Enrolled:_____ Height:_____in Initial Weight:_____lbs BMI:_____
Ideal Body Weight:_____lbs Excess Body Weight:_____lbs Max Weight:_____
Weight at Surgical Consult:_____lbs Vitals: BP_____ HR_____ Temp_____

Eating Habits: __Sweets __Junk Food __High Calorie Beverages __Large Portions __Snacking __Comfort __Stress Eating

PMH: __Morbid Obesity __Hypertension __OSA __NIDDM __IDDM __GERD __PCOS __OA __LBP/DJD __Hypercholesterolemia __Hyperlipidemia __Depression __Anxiety __Stress Incontinence __Venous Insuficiency __Cholelithiasis __Other:

PSH: _____
_____

SH: Employed_____ __Marital Status __ Tobacco __Alcohol

FH: __Obesity __CAD __DM __Cancer __Bleeding Disorders __Anesthesia Problems

Exercise: _____

Allergies: _____

Current Medication	Dose	Freq

Labs	Date	Status
CBC		
CMP		
Lipids		
PTH		
TSH		
H. Pylori		
Iron		
Folate		
Vit B1/B12		
Vit D		
Hgb A1C		

Testing	Date	Status
EKG		
Stress Test		
Sleep Study		
RUQ US		
Psychology		
Mamogram		
Colonoscopy		
EGD		

Plan: ___Bypass (Short) ___Bypass(Long) ___Band ___Sleeve
Visit Dates: _____Initial Consult _____Preop Visit
Post Op Scripts Written: ___
Informed Consent Signed: ___